A Family Planning Program
for Women Ages 19-44

Application for the Medicaid Plan First Program

This application is for women ages 19-44 who **DO NOT HAVE CHILDREN** under 19 years of age in the home. (Women with children under age 19 in their home will need to fill out the blue SOBRA joint application, Form 291.)

The Plan First program is for family planning services only.

If you have questions, please contact your local health department, or call Medicaid at 1-800-362-1504. The call is free.

Form 357 (09/2006) Alabama Medicaid Agency

Please print using dark ink. **Plan First Application (Form 357)**

1. Application was Completed at: ____ Health Department ____ Doctor's Office

____ Home ____ Other_____

2. Name of Applicant:_____
(First Name) (Middle Name) (Maiden Name) (Last)

Social Security Number:_____ **Date of Birth:**_____ **Age:**_____

City or Town of Birth:_____ **County of Birth:**_____ **State of Birth:**_____

3. Applicant's Mother's Full Maiden Name:_____
(First Name) (Middle Name) (Maiden)

4. Applicant's Father's Name:_____
(First Name) (Middle Name) (Last)

5. Race:_____ **Do you receive Medicare?** Yes___ No___

6. Are you a female? Yes___ No___ **Have you had your tubes tied or been sterilized?** Yes___ No___

7. Are you a U.S. Citizen? Yes___ No___ (Citizens must provide proof of citizenship and identity. See Citizenship and Identity handout for documents needed. Qualified immigrants must provide proof of immigrant status.)

8. Telephone Numbers where we can call you:

Cell Phone: (_____)_____ Home Phone: (_____)_____

Work Phone: (_____)_____ **May we contact you at work?** Yes___ No___

Other Phone: (_____)_____ Whose Phone?_____

9. Address where you want your Medicaid card sent:

_____
Street address or rural route number City State Zip Code County

Address where you live, if different from above:

_____
Street address or rural route number City State Zip Code County

10. Name of Spouse:_____

Spouse's Social Security Number:_____

Spouse's Date of Birth:_____ **Race:**_____

For Official Use Only

Date Received at Public Health_____

Date Accepted at Medicaid_____

11. Do you have health/hospital insurance? Yes___ No___

If yes, name of policyholder: _____

Name and Address of Insurance Company: _____

_____

Policy Number:_____ **Group Number:**_____ **Effective Date:**_____

12. Income **If you have no income, check here _____. If your spouse has no income, check here _____.**

13. Earned Income **Complete the section below if you or your spouse have income from work.**

(If self-employed check here _____.)

Your Income: How often are you paid? Weekly____ Every 2 weeks____ Monthly____ Other _____

Day of week paid: _____ Gross amount paid per paycheck: $_____ (include all tips)

If hourly employee, hourly rate: $_____ Hours worked per week: _____

Name, address and telephone number of employer: _____

_____

Spouse's Income: How often is he paid? Weekly____ Every 2 weeks____ Monthly____ Other _____

Day of week paid: _____ Gross amount paid per paycheck: $_____ (include all tips)

If hourly employee, hourly rate: $_____ Hours worked per week: _____

Name, address and telephone number of employer:_____

_____

14. Unearned Income **Complete the section below if you or your spouse have income from any of the sources listed.** Please list the **GROSS AMOUNT** (amount before anything is taken out).

1. Social Security
2. SSI
3. Public Assistance
4. Railroad Retirement
5. Veterans Benefits
6. Federal Civil Service
7. State Retirement
8. Private Pension
9. Miner's Benefits
10. Black Lung Benefits
11. Cash Contributions
12. Rental Income
13. Personal Loans
14. Unemployment Comp
15. Insurance Annuity
16. ASCS Gov't payment
17. Coal, Oil, Timber
18. Leases
19. Child Support from a Legal Parent
20. Interest on Savings
21. Other: (Explain) _____

Name of Person Receiving Payments/Benefits	What Source-From Above	Gross Amount Received	How Often are Payments Received?

RELEASE OF INFORMATION

* I hereby authorize and give my consent for the Alabama Medicaid Agency to obtain information from any source for the purpose of determining my eligibility for Medicaid benefits. I authorize this release form to be in effect for as long as I am on Medicaid regardless of the date that it is signed. I further authorize copies of this document to be used in place of the original. I give my consent for the release of information for those purposes directly related to the administration of the Medicaid program. These purposes include, but are not limited to, establishing eligibility for benefits, determination of the amount of medical assistance received, the provision of services, and investigation of program violations.

AGREEMENT AND AFFIRMATION

* I give permission to the Alabama Medicaid Agency to use my social security number to get information about my income from banks, financial institutions, employers, and other county, state and federal agencies, and/or to see if I qualify for assistance or to see if I have insurance.
* If I am approved for Medicaid, I assign all insurance and medical support benefits to Medicaid. If Medicaid pays my bills, then my insurance or other benefits (such as lawsuit settlements) must be used to pay Medicaid back. I agree to help and cooperate with Medicaid in identifying and collecting this money, or I may lose my Medicaid benefits. I give permission for my insurance company, employer, and others to give needed information to Medicaid in order to administer the Medicaid program.
* It is my understanding that my case is subject to review by state and/or federal quality control.
* I understand that I may ask for a hearing if a decision is not reached on my case within the proper time limit or if I disagree with the decision reached.
* I agree to tell the Alabama Medicaid Agency immediately or in no more than 10 days if I receive additional income, if I move or if any changes occur in my circumstances.
* I understand and agree that I and my spouse must take all necessary steps to get any benefits such as annuities, pensions, unemployment compensation or retirement disability benefits that we may be entitled to.

FALSE STATEMENTS

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining eligibility of Medicaid commits a crime punishable under federal or state law or both. I affirm under penalty of perjury that all information I give in this document or in support of it is true.

Signature: _____ Date: _____

Name and phone number of person helping to fill out this form: _____ Date: _____

Mail this form to:

Alabama Medicaid Agency
Plan First Intake Unit
Attn: Vicki Wilson
501 Dexter Avenue
P.O. Box 5624
Montgomery, AL 36103-5624

Medicaid eligibility policies and procedures are in compliance with the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Federal Age Discrimination Act of 1975 and the Americans with Disabilities Act of 1990.